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Annual Address of the President PROVIDENCE MEDICAL ASSOCIATION

January 3, 1938

RECENT CONCEPTS OF CANCER TREATMENT

PETER PINEO CHASE, M.D.

122 WATERMAN STREET, PROVIDENCE, R. I.

We have all been impressed with the campaign against cancer which has been developing intensively the last few years. I believe it was Wellington who said, "War is guessing what the other fellow is doing on the other side of the hill." So the metaphor is apt when we speak of the war on cancer. We know when its attack has come into the open but when it will strike us or why, we know not.

There have been and there are still coming, theories galore. The infection theory has been strongly urged but apparently is generally discredited now. The role of viruses has much experimental support in certain types of cancer. Chronic irritation is the best known and best authenticated precursor of cancer—the cheek cancer in betelnut chewers, abdominal cancers in tribes who carry baskets of live coals under their robes and the many carcinogenic agents in industry and experimental laboratories—but these are not sufficient explanations in themselves. There are thousands of mouths in Providence with jagged teeth and the rottenest of hygiene. A few score at the most will show mouth cancer.

The laity are firmly convinced that cancer follows a single injury and apparently a large part of the profession agrees with them. Post hoc ergo propter hoc. With the innumerable greater or lesser bruises and bumps the human race is continually receiving a goodly proportion of cancer patients can look back to what they believe are causative injuries. And the courts are prone to agree with them. Recently a powerful negro stevedore wrenched his forearm. He testified he stopped work for only a few minutes, called no one's attention to it and continued on the job till the vessel was empty a few days later. Next week he reported to a physician with a swelling several inches in diameter. From then on the swell-

ing grew no more and in a few weeks an operation showed a sarcoma. The judge ruled that the accident caused the cancer. But laboratory experiments produce no cancer by anything like single traumas and the incidence of cancer in hundreds of thousands of injured persons followed by insurance companies and army surgeons after the Great War is no greater than in the general population. Perusal of the proceedings of cancer congresses or the multitude of papers on cancer will show that this hypothetical cause is practically ignored except for medico-legal discussions.

A striking relation between the hormones and cancer apparently exists. The Memorial Hospital in New York has shown that the results of radiation in testicular tumors can be followed by the quantitative estimation of prolan in the urine. Marked relationship between ovarian hormones and breast cancer is being demonstrated even to the extent of regression of the advanced disease when the ovarian hormones are destroyed by radiation. Inheritance, environment and social conditions all seem to be implicated and back of all this there may be fundamental physiological cell conditions as yet beyond our knowledge. In general it seems more and more certain that no single simple theory of cancer will suffice but an interplay of many factors of varying significance in different types and cases.

It is evident that more cancer is being seen than formerly but is it actually increasing? No doubt due to increased knowledge and skill a larger proportion of cases are being recognized. The incidence of cancer increases with age and the average length of life is advancing so that there is undoubtedly more opportunity for cancer to develop. In this way only probably is cancer increasing.

Frequent reference is made to the typical signs of cancer. This is a poor phrase as cancer is not typical except possibly in its advanced stages. It is protean in its manifestations or what is fully as probable gives no demonstrable manifestation until well developed. Our numerous criminals today are often

helped in their nefarious careers by the legal maxim that a man is innocent until proved guilty. Don't give cancer that chance. To change the figure, this isn't a cricket match but a street fight. Everything goes. Any change in bodily appearance or function, especially but not necessarily as age increases, must cause suspicion. Any ulcer that persists, any new lump or swelling, persistent bleeding or discharge, change of bowel function, persistent indigestion—as Dr. Churchill will probably impress on you, something different going on in the lungs. They may all be cancer and that is the time to fix them. And don't let syphilis fool you. They gang up together, especially in the mouth. A year or two ago a small pimple or pustule appeared on the back of the hand but it didn't clear up or get worse. The sharp point of a knife didn't free the expected droplet of pus. Biopsy with the immediate examination showed epidermoid carcinoma and a square inch or so of skin was cut away. We have seen a thousand pimples that looked like this but they got better or worse soon.

There is only one fixed rule for the treatment of cancer and that we got from Donnybrook Fair, "When you see a head, hit it." And like the lad with the shillalah, "Hit hard." You will never have a better chance than your first one. But team work is exceedingly important. At least three agents have proved their value, surgery, x-ray and radium. Each case must be approached with an open mind as to which one agent or combination shall be used. In general, distrust the man who emphasizes one agent in the treatment of cancer. Even in a field so pre-eminently that of the surgeon as breast cancer, Mr. Keynes of London with his use of interstitial radium is causing a doubt as to whether we will always be doing our horribly mutilating operations. A woman with a cancer of the tongue had interstitial radium twice, two operations on the tongue and x-ray over the neck. For four years now she has been in fine condition. Another important member of the team is the pathologist. It is no longer bad form to do a biopsy on a cancer case. Not only can the pathologist usually say whether or not it is cancer but his grading as to degree of malignancy is frequently of value in selecting the agent for treatment.

But there are still many gloomy members of the profession who shake their heads and question the worth-whileness of cancer treatment. Operations are mutilating. You are never sure you have a cure.

Life with a colostomy is worse than death, etc. The answer to the first is that many mutilations can be covered up and life is usually sweet even to people with facial disfigurements. You are never in doubt about heart disease or diabetes. You know you have not cured them. But the patient appreciates palliation in these and in cancer. Dr. Daniel Jones with an enormous experience felt that his colostomy patients were very contented. Two of the most satisfied patients I know have colostomies. Ewing says, "Cancer is the most curable of the major causes of death and in this field the physician renders some of his most valuable services or makes his most regrettable mistakes."

The American Society for Control of Cancer and particularly its branch, the Women's Field Army, have conducted an earnest campaign to educate the laity about cancer. There is no doubt that the profession has needed education also. Being such a disagreeable subject doctors have shrunk from it, particularly because of their pessimistic view of the results of treatment. One good way to cause a change in this attitude is to visit cancer clinics, study the diagnoses, see the apparent cures and what is probably even more important the palliations. In many states now diagnostic clinics are established at strategic points which can act as sorting stations and handle directly the more straight-forward cases. But the difficult diagnostic problems, and especially much of the treatment, require central institutions with large specially trained staffs and much equipment. In discussing the evolution of the cancer problem Ewing says, "The final and most important development was the creation of special cancer hospitals and institutes combining clinical and pathological studies, gathering large numbers of cancer patients in one place and leading to much greater specialization in all departments."

Geographically, Rhode Island is a small area and outside the Providence vicinity it would seem unreasonable to have such a center. There has been some attempt to start a movement for diagnostic clinics in the outlying districts but they have not so far responded, feeling that any difficult problem can easily be brought here. The Rhode Island Hospital now has a clinic some years old with pathologists well trained in tumor diagnosis, an efficient x-ray plant for treatments, about five hundred milligrams of radium and a group of doctors representing various specialties who have observed this large clinic

for several years. Judging from the relation of equipment to population in other centers it would seem wasteful to duplicate all this in a community of our size. But one endowed hospital can not afford now to do all this work for the community. There would seem to be two solutions open to us,—first, state-supported care of cancer patients. Massachusetts and New Hampshire are two of our neighboring states doing this. Apparently sentiment among us is at present strongly against any radical increase of state medicine—second, the establishment of a privately endowed cancer hospital as the Memorial in New York, the Huntington and Palmer Memorials in Boston. This would seem to be the ideal solution. Let us hope that some of our well-to-do citizens will contribute to this humanitarian purpose money that otherwise would be taxed from them and expended in dubious governmental manners.

In most large centers of civilized population cancer hospitals have been established. Here the populace learn they can get intelligent care and hence quacks flourish less. Pathologists and clinicians seeing large groups of cases understand the diverse aspects which cancer especially presents both for diagnosis and treatment. Reduplication and overlapping of specialized, expensive and dangerous agents like x-ray and radium are prevented. Opportunities for study, teaching and research are presented. Providence is the logical place for such an institution. Earnest efforts should be made to bring this need to the attention of our populace.

SOME THEORETICAL AND THERAPEUTIC CONSIDERATIONS OF THE ANEMIAS

EUGENE L. SIELKE, M.D.

RHODE ISLAND STATE HOSPITAL FOR MENTAL DISEASES

It is virtually impossible to discuss the anemias without entering into the consideration of a certain amount of physiological theory and experimental work. In this presentation, perhaps somewhat platitudinous, I have tried to reduce theoretical aspects to a minimum and confine myself mainly to practical applications, to diagnoses and treatment, especially that which may interest us in our work here.

Read before the Journal Club at the State Hospital for Mental Diseases, December 17, 1937.

In the first place it is necessary to gain a vantage point from whence one can achieve a certain perspective and comprehensive grasp of the anemias as a group. This can best be attained by adopting a simple system of classification. The old system of primary and secondary anemias was quite simple; in fact, too simple, *but*, in the light of present knowledge, woefully inadequate and contributing little to an understanding of etiology and treatment. A classification, widely accepted at present, follows, with some pertinent and practical considerations.

I. In the first group are pernicious anemia and other related macrocytic anemias. These are all characterized by an anemia in which the red blood cells are larger than the normal; that is, macrocytes.

In this group, besides pernicious anemia, there are sprue, pellagra, postgastric resections, intestinal short circuits and stenoses, chronic dysentery, idiopathic steatorrhea, pregnancy, dibothrycephalus latus infestation, and other less well defined states of malnutrition and liver disease. The etiology of the anemias arising from all the foregoing conditions is considered to be a nutritional defect of the blood marrow. Castle of Boston has postulated a basic hypothesis with which most of us are familiar and which until today has not been generally discredited. It helps greatly in the understanding of these anemias. This hypothesis states that, *normally*, bone marrow nutritional deficiency does not occur because of the presence in the food of a substance—the so called extrinsic factor—which, together with a specific principle of the normal gastric juice—the so called intrinsic factor—leads, after absorption from the normal alimentary tract, to the production of a thermostabile substance stored particularly in the liver and kidney, and at present known, for want of better isolation, as liver extract. The beforementioned anemias are, therefore, liver extract deficiency anemias. This deficiency of liver extract can be brought about in three different ways, singly or in combination; first of all, by deficiency of the extrinsic factor—a food deficiency. This extrinsic factor is found mainly in animal proteins such as meats or eggs, but not in vegetable proteins. Secondly, by deficiency of intrinsic factor as in pernicious anemia, gastric resection, or any condition producing achylia and loss of the intrinsic factor normally formed in the stomach mucosa near the pylorus. Thirdly, by altered permeability of the intestinal tract so that the above two factors are not absorbed and used in the forma-

tion of the third substance, liver extract. This last condition can occur in the chronic diarrheas. In sprue there is a lack of extrinsic factor in the diet associated with impaired intestinal absorption because of the diarrhea and altered intestinal permeability. Pellagra is apparently due to the same two causes plus the vitamin B complex deficiency. It is easily seen that these anemias, including pernicious anemia, would, under the older terminology, be in reality secondary anemias, and also that all these anemias are responsive to treatment with liver extract by supplying that deficiency.

The cause of the deficiency of the intrinsic factor and the achlorhydria in pernicious anemia is still not defined, but the present trend of experimental evidence seems to indicate that there is first of all a constitutional tendency present, which under the influence of a chronic nutritional deficiency finally leads to the development of the classical signs of this disease. Infectious causes for pernicious anemia as well as for the associated gastritis and glossitis have been mainly discarded.

II. The second large group of anemias are the hypochromic or microcytic anemias. These arise chiefly because of a failure in the production of hemoglobin. The hypochromic anemias are usually small-celled or microcytic in type and have recently been known as iron deficiency anemias. Some abnormal mechanism for causing loss of iron is necessary to produce a hypochromic anemia. The loss of available iron may be relative, as with rapid growth and consequent increase in blood volume, or absolute, as with hemorrhage or as in the transfer of hemoglobin building factors from mother to fetus. In the common chlorosis of bygone days, but of which many cases still occur, there is both the relative and absolute loss of hemoglobin building materials because of growth, in the first place, and menstrual blood loss in the second. If the diet is deficient in iron or the alimentary tract is unable to assimilate it from the food, the loss of iron will exceed the intake and a hypochromic anemia result. The incidence of this type of anemia is much greater than the average physician appreciates, and in our own hospital is probably the most common. A recent survey on 3,500 individuals from the poorer classes in Aberdeen, Scotland, showed that 16% of adolescent women and 45% of adult women had hypochromic or iron deficiency anemia. An interesting and practical fact brought out in this report was that anemia was absent in all males except in association

with some organic disease. The association of this type of anemia in women with the chronic blood loss of menstruation is obvious. Unless the amount of iron in the diet is greater than the average during a woman's menstrual life an iron deficiency state or hypochromic anemia can easily arise.

III. The third large group of anemias are the so called hemolytic types of which the outstanding cause is an increased destruction of red blood cells. There are several sub-groups which might be mentioned in passing. First are what is known as the paroxysmal hemoglobinurias, under which is included the so called cold type which has been related to syphilis but which, however, also occurs in non-syphilitic individuals. In this type hemolysis of the blood occurs on exposure to cold. A second type of hemoglobinuria is what the Germans call march hemolysis, really an exertion hemolysis, which occurs on prolonged physical activity. A third type, more common in animals, especially the horse, is the paralytic hemoglobinuria in which the muscles become weakened by hemolysis of the hemoglobin in them, leading to a paralysis. A fourth recently defined type is the nocturnal hemoglobinuria which occurs without any known cause, only during sleep. This last type eventually proves fatal. Erythroblastic anemia in children, sickle cell anemias, chronic hemolytic icterus, and the blood destruction due to such drugs as benzol and sulphanilimide are all anemias due to increased blood destruction, and are classified under this third group.

IV. In the last or fourth group of anemias one can include all those arising from the so-called hemorrhagic diseases, under which are included hemophilia, scurvy, and the various purpuras.

With this brief survey of the anemias we can summarize some of the most important etiological factors in their production. First is the question of diet. For a diet to provide adequate materials for normal blood building it must contain three important substances; an adequate daily intake of iron, which in the adult is about 60 mg.; sufficient amount of animal protein; and lastly, adequate amounts of vitamin B complex and C. These latter vitamins have been proved necessary for normal blood building. Next in etiological importance are gastric and intestinal abnormalities and interference with the formation of intrinsic factor in the stomach and formation of liver extract substance and its absorption or storage in the liver. Achlorhydria is important, as in this condition iron is not as well assimilated

lated as when the hydrochloric acid content of the stomach is normal. Chronic intestinal disorders such as dysentery and chronic diarrheas also interfere with the absorption of iron from the diet. Various types of liver disorders, such as the cirrhoses, interfere with the formation and storage of the necessary liver substance or extract and lead to the specific macrocytic anemia. Other less common but important etiological factors are those which interfere directly with the normal function of the bone marrow without there being any deficiency of blood building materials as with certain chemical poisons such as radium, benzol or arsenic, producing so-called aplastic anemias. Carcinoma, leukemia and Hodgkin's disease cause anemia by their direct effect and by crowding out of the blood building elements of the bone marrow. Increased blood destruction leads eventually to anemia, as has been noted.

Treatment

After all is said and done the important practical consideration in the treatment of the anemias is the determination of the particular type and its etiology. Only after this is done can a rational outline or program of treatment be initiated. The alleviation of the anemia and the concomitant symptoms in the shortest possible time and at the least expense to the patient or hospital is directly dependent on a correct diagnosis. Shotgun prescription methods and the administration of liver extract and iron in every case of anemia, no matter what the etiology, is both expensive and often valueless. In the anemias an adequate history, physical and laboratory examination is essential as in all diseases. In the history attention is particularly paid to previous dietary habits, gastro-intestinal symptoms, neurological manifestations and hemorrhages of any sort. The physical examination must include a search for lymph adenopathies, enlarged spleen and liver, purpuric spots and petechia as well as a neurological examination. The laboratory contributes to the diagnosis by gastric analysis, stool examinations for blood, icteric index, fragility tests and careful blood examination. Gastro-intestinal x-rays and x-ray examination of the bones is at times indicated. When all the data is assembled, a diagnosis can usually be made and the treatment then is simple. The macrocytic or liver extract deficiency anemias respond promptly and specifically to the administration of liver extract.

Sixty times as much liver extract must be administered orally as parenterally for the same reticulocytic response. The advantage, at least economically, for giving the extract by injection is obvious. Cases of pernicious anemia with advanced neurological involvement appear to need larger doses than the ordinary types. Because of the variable potencies of different extracts as put out by the commercial companies a standard dose cannot be given. However, recently there has been successful agitation for approving liver and stomach preparations in terms of units and this will soon be generally adopted. A unit is defined as that amount of material given daily, orally or by injection, which produces satisfactory reticulocyte rises and increases in erythrocytes and hemoglobin in a patient with Addisonian pernicious anemia.

The general administration of liver extract in hypochromic, hemolytic or the anemias due to increased blood destruction is frequently useless and always expensive. In the hypochromic anemias iron is the important therapeutic agent. The average daily dose of various common iron preparations to insure maximum effects is reduced iron 3 gm., mass of ferrous carbonate 4 gm., ferric and ammonium citrates 6 gm. and ferrous sulphate 1 gm. In the presence of achlorhydria the use of the soluble forms such as the citrates and the ferrous sulphate are preferred. Because of the convenience, smaller adequate dose, and better tolerance, the trend is towards the use of ferrous sulphate, which is both inexpensive and therapeutically active and can easily be administered in capsules. In the anemia due to scurvy, all symptoms as well as the anemia respond specifically to the administration of Vitamin C. Idiopathic disturbances of the blood forming organs such as the hemolytic and hemorrhagic groups mentioned are *not* amenable to drug therapy as far as the anemia is concerned, but are treated symptomatically or surgically as by splenectomy in chronic hemolytic icterus or thrombocytopenic purpura. No amount of liver extract or iron will influence the anemia of aplastic anemia, purpura, agranulocytosis or leukopenia.

If this presentation has done nothing else but bring home the fact that liver extract will not cure every anemia, it has been decidedly worth the effort.

It is hoped also that this brief sketch of the anemias has fulfilled its purpose of crystallizing some of the more important concepts now in vogue.



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CONGRATULATIONS TO DR. PERKINS

In January 1938, Dr. Jay Perkins resigned as President of the Providence Tuberculosis League and was elected *President Emeritus*. In retiring from active leadership in community tuberculosis work, he leaves an enviable record of service extending over 44 years.

His interest was first aroused when, in 1894, working with Dr. Gardner T. Swarts, he was impressed by the danger to the community in the number of positive sputum cases found. From this time on the high lights of his activities in this field mark the milestones in the organized fight against tuberculosis in Providence. In July 1900, he organized the tuberculosis clinic at the Rhode Island Hospital and served as its active head until 1920. In association with Dr. Charles V. Chapin, Dr. Swarts, and others he worked incessantly to arouse public sentiment for a state sanatorium, facilities for the care of far advanced cases, and greater general participation by the public in the fight against tuberculosis.

The year 1905 was a memorable one in that many of the developments that Dr. Perkins was working for were achieved. He became a charter member of the National Tuberculosis Association. The State Sanatorium opened its doors and he served as visiting physician for two years. He became physician in charge of the tuberculosis branch of St. Joseph's Hospital at Hills Grove. The Providence Society for Organizing Charity appointed him as chairman of the Committee for the Relief and Control of Tuberculosis. Later this committee developed into the Providence Tuberculosis League. He has continued as President of the League until now.

In 1907, Dr. Perkins helped in the formation of the Rhode Island Tuberculosis Association and served as director. In 1910, largely through his efforts, money was raised to purchase the Lakeside property for the Society for Organizing Charity. Lakeside was managed by this organization until formation of the Tuberculosis League which manages it today. In 1910, on the opening of the Charles V. Chapin Hospital, he allied himself with the tuberculosis work there, and in 1921 was elected physician in charge of the tuberculosis department.

It is interesting to note not only that the fundamental principles which were the basis of the work of his committee in 1905 are practically the same as those in use today but also that the methods employed then have since proved their worth.

The JOURNAL congratulates Dr. Perkins on a far-reaching and effective public service in the control of tuberculosis, and wishes him comparable success and happiness in his other work.

SMALLPOX

During the first eight weeks of 1938, there were 4550 cases of smallpox reported in the United States, compared with 2364 during the same period of 1937. Judging from the reports, the following states might concentrate more on compulsory vaccination: Ohio, Indiana, Illinois, Michigan, Minnesota, Iowa, Missouri, North Dakota, Nebraska, Kansas, Kentucky, Tennessee, Oklahoma, Texas, Montana, Idaho, Colorado, Arizona, Washington, Oregon and California.

ANNIVERSARY DINNER

The President of the Rhode Island Medical Society has appointed a committee to consider and report on the advisability of charging those who attend the annual dinner an amount sufficient to cover the expense of the banquet. Under the present arrangement, the Society pays from the treasury for the dinner which is attended by only about a half of the members. The committee may presume that the half of the members who do not attend the dinner are not in favor of paying for those who do attend. A canvass of those who do attend reveals a majority who are in favor of charging a fee sufficient to cover the expense and perhaps to show a profit for the treasury. Some are in favor of reducing the annual dues by a corresponding amount, while others hold that the Society could make use of the extra amount for more worthwhile purpose. However, the opinion of the minority who favor the present status must still be taken into consideration. But they must consider that, due to present conditions, no longer do all the members who are able gather in old Masonic Hall for a well-earned celebration of accomplishment of a year's work. In fact, the percentage of members attending this banquet is constantly diminishing. Is it then expedient for the entire Society to pay for this minority?

If the majority rules, the anniversary dinner, in the near future, will be paid for by those who are present. However, in deference to the minority, no change should be hastily made in a custom so honored by time.

TO THE EDITOR

Newport Hospital

Newport, R. I., March 15, 1938.

Albert H. Miller, M.D., Editor,
Rhode Island Medical Journal,
Providence, R. I.

My dear Dr. Miller:

Your interesting editorial in the March edition under the caption "No Physician on the Hospital Board of Trustees" prompts me to attempt an answer to your query as to why active staff physicians are not usually members of hospital Boards of Trustees.

Although an exception to the general rule, our policy at Newport Hospital is apparently in line with your viewpoint that at least one active staff member should be on the hospital governing board. The President of our Staff is automatically an ex-officio Trustee, expected to attend all meetings. As our staff officers are elected annually and by long precedent remain in office only two years, there is a fairly frequent change of personnel in the representative from the Staff, and this policy for our institution has proved a happy one for all concerned.

Channing Frothingham, M.D., the Faulkner Hospital, Jamaica Plains, Mass., President of the Massachusetts Medical Society, presented an interesting and perhaps an original grouping of Staff representation last Friday at the N. E. Hospital Association convention in Boston in his discussion of "Staff Committees and Their Relationship to the Trustees." In the course of his discussion he stated his opinion that while he did not favor active staff members on a hospital Board of Trustees, he did think that certain capable physicians who had been members of hospital active staffs or who were Consultants, should be made members of Trustee Boards.

In his book, "Hospital Organization and Management," published in 1935, Malcolm T. MacEachern, M.D., Associate Director, American College of Surgeons, writes (pages 79 and 80), as follows:

"On the other hand, the small body of about seven members may be carefully selected and is found to be more effective. In addition, it is also found that, arising out of this interest in the hospital, the activities of the members are gradually extended until they become a vital factor in the welfare of the community. If broader contact for the hospital is required it may be secured through the appointment of an advisory board which may have as many members as necessary, but such a group can not be authoritative. It is controlled by the governing body. The advisory board must be available when the services of its members are required to supplement the more circumscribed activities of the governing body."

"A number of hospitals report favorably on the practice of having the medical staff represented on the governing body, but this policy is not in accordance with the principles advocated by the American Hospital Association and many hospital

authorities advise against such appointments. Membership on the governing body gives publicity to the individual physician, thereby placing him in a position which he may not have earned by his professional efficiency, and favorably affecting his private practice. There is the further danger that the staff may come to regard the physician member in the light of an inspector who is unduly critical of other physicians and of their work. Such an attitude creates a barrier which prevents any real cooperation between the governing body and the medical staff. Some institutions, believing that it is desirable to have the medical point of view represented on the governing body, appoint a retired physician as a member. There can be no serious objection to this procedure provided the physician selected is one who keeps abreast of medical progress, appreciates the needs of the modern hospital, and refrains from interfering with the administration. Occasionally there is a tendency on the part of the medical representative to express his own personal judgment rather than the collective or group opinion of the body he represents. The problem of securing the medical point of view is best solved not by representation on the governing body but by making provision for the staff to select a committee of its members who will meet in joint conference with a committee of the governing body and the administrator."

Sincerely yours,

HARRY J. DUNHAM,
Superintendent

THE BEHAVIOR OF CHILDREN RECEIVING BENZEDRINE

CHARLES BRADLEY, M.D.
EAST PROVIDENCE, R. I.

Bradley (*Am. J. Psych.* 94:577, Nov., 1937) reports on the effects of Benzedrine Sulfate, administered to a group of 30 "problem" children, aged 5 to 14 years, under very favorable conditions.

The children chosen for the study manifested various behavior disorders, ranging from specific educational disabilities to the retiring schizoid type

and the aggressive, egocentric epileptic. They were observed, without subjective questioning, by a special psychiatric nurse for a period of 3 weeks. Each child received a daily morning dose of Benzedrine Sulfate during the second week, the first and third weeks being regarded as control periods. Twenty mg. was the usual dose, but this varied according to the individual.

Although these children had been receiving the usual intensive training available at the Bradley Home, 14 of them, or 47%, promptly "responded in a spectacular fashion" to Benzedrine Sulfate therapy, showing marked improvement in speed of comprehension and accuracy of performance, together with a keen desire for accomplishment. Eight others showed some improvement. In all cases improvement disappeared the first day therapy was discontinued.

In emotional response, 15 children, or 50%, became subdued. Seven of these were of the erratic and aggressive type, and the author suggests that Benzedrine Sulfate, by stimulating the higher centers, may increase voluntary control in such cases. Seven other children reported a definite euphoria. The remaining 8 had varied responses. One case of agitation and two cases of anxiety were observed.

In spite of the "attractive results obtained . . . and the apparent low toxicity of the drug," the author concludes that it is too early definitely to recommend Benzedrine Sulfate in the general treatment of pediatric behavior problems, and that additional studies should be made in this field.

LEUKOPLAKIA AND TOBACCO

F. RONCHESI, M.D.
PROVIDENCE, R. I.

Ronchese reports two identical cases of Leukoplakia Buccalis, also very improperly called "smoker's palate," one involving a heavy smoking man and the other a non-smoking woman, to suggest that there is no proof that tobacco is a direct cause of Leukoplakia Buccalis as it is maintained by the great majority of the authors.

Archives of Dermatology and Syphilology, 36:1222, December 1937.

RHODE ISLAND MEDICAL SOCIETY**Budget Approved January 20, 1938**

Collations and Annual Dinner.....	\$700.00
Expenses of Secretary.....	85.00
Printing and postage.....	200.00
Fuel.....	600.00
Gas.....	45.00
Electricity.....	95.00
Telephone.....	100.00
City water.....	15.00
House supplies and expenses.....	350.00
House repairs.....	300.00
Janitor.....	720.00
R. I. Medical Journal.....	450.00
Safe Deposit.....	7.00
Treasurer's Bond.....	25.00
Librarian.....	1,660.00
Delegate to American Medical Ass'n.....	100.00
Medical Library Association Dues.....	10.00
Sunday Lectures.....	125.00
	<hr/>
	\$5,587.00

INCOME FOR 1938

Annual Dues.....	\$4,700.00
Interest from Harris Fund.....	210.60
Interest from Morgan Fund.....	25.80
Providence Medical Association.....	450.00
Use of Building.....	75.00
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	\$5,461.40
Balance in Bank Jan. 1, 1938.....	1,744.48
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	\$7,205.88

HARRIS FUND

26 shares Nicholson File Co.....	\$54.60
General Public Utilities Co.....	156.00
Mortgage Security Corp. of America.....	
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	\$210.60

JAMES R. MORGAN FUND

43 shares Providence Gas Co.....	\$25.80
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WOONSOCKET MEDICAL SOCIETY

The regular meeting of the Woonsocket District Medical Society was held February 8, 1938 at 8:00 P. M. at "LaMartinique." After the usual supper, a business session was held.

Dr. E. Parker Hayden gave a very interesting and comprehensive lecture on "Diseases of the Rectum and Colon." The lecture was thoroughly illustrated with lantern slides.

PROVIDENCE MEDICAL ASSOCIATION**Minutes of the February Meeting**

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Alex. M. Burgess, on Monday, February 7, 1938 at 8:40 P. M.

The minutes of the last meeting were read and approved. Their applications having been approved by the Standing Committee, the following were elected to membership:

Eugene Norton Granger
George Harold Alexander

Dr. Francis J. McCabe read an obituary of the late William C. McLaughlin. It was voted to spread this on the records and to send copies to the family and to the Rhode Island Medical Journal.

Dr. Edward S. Cameron reported two cases of disease of the small intestine, one a case of obstruction due to Meckel's diverticulum, and the other a tumor of the small intestine causing intussusception. The pathological specimens were demonstrated.

Dr. Wilfred Pickles read an obituary of the late Harvey E. Wellman. It was voted to spread this on the records and send a copy to his family and to the Rhode Island Medical Journal.

The scientific program was on the subject of "Pneumonia—A Medical Emergency." The first paper was given by Miss Esther Brintzenhoff and was entitled "Bacteremia in Pneumonia." The second paper of the evening was entitled "Non-specific Measures in the Treatment of Pneumonia" and was presented by Dr. Charles F. Gormly. Dr. Maxwell Finland gave the third paper which was entitled "The Specific Treatment of Pneumococcus Pneumonia."

The papers were discussed by Doctors John C. Ham, William S. Streker, Leo Cohen, and William H. Higgins.

The meeting adjourned at 10:55 P. M.

Attendance 180. Collation was served.

Respectfully submitted,

HERMAN A. LAWSON, M.D., *Secretary*

Rhode Island Association of Record Librarians

The regular meeting of the Record Librarians' Association of Rhode Island was held in the Medical Library at 3:30 P. M. on February 17, 1938.

There were ten members present, Elizabeth M. Bingham presiding. A letter was read with reference to the meeting of the New England Hospital Association to be held at the Statler Hotel, Boston, Massachusetts, on March 11, 1938. A motion was made and seconded that due to the fact that most of the members will be attending the N. E. Hospital Association meeting, the regular meeting for next month be omitted. Questions were read and discussed. There being no further business, the meeting was adjourned.

Respectfully submitted,

MARY NUNEZ, *Secretary*

REPORT OF THE MILK COMMISSION OF THE PROVIDENCE MEDICAL ASSOCIATION

Certified milk in Providence during 1937 was obtained from the following farms: Cocumcussoc Farm, Wickford, R. I.; Cherry Hill Farm, North Beverly, Mass.; Fair Oaks Farm, Lincoln, R. I.; Ferrycliff Farm, Bristol, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass.

Through the courtesy and cooperation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire. During the year Ferrycliff Farm of Bristol, R. I., has been certified by the Commission. This farm, which is owned by Dr. and Mrs. Halsey DeWolf, has been in continuous operation for 61 years and is producing an excellent grade of Jersey milk. During these years the herd has always consisted of pure bred registered Jersey cattle.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart. During the year experiments have been carried on to determine the presence or absence of B-Coli in milk and some of this work has been done on certified milk. The potency tests on the Vitamin-D milk have been carried on in the laboratory of Professor Philip Mitchell and all tests showed a minimum of 400 U.S.P. units per quart.

During the summer the Commission was fortunate in having Mr. B. J. Brown of the National Headquarters spend several days in Providence visiting and inspecting the three local farms under our direct supervision. His helpful suggestions have been of great value to the Producers and members of the Commission.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections. Pamphlets concerning the qualities of certified milk have been given to new mothers and the commission is sending out a series of letters to members of the Providence Medical Association and the Rhode Island Dental Society stating the essential facts of this milk. In this way we hope to acquaint the members of each society with the excellence of certified milk and bring about a wider distribution of this product.

The personnel of the Commission includes Drs. Harold G. Calder, Chairman; Reginald A. Allen, Francis V. Corrigan, Banice Feinberg, William Hindle, Henry E. Utter, George W. Waterman, Raymond L. Webster of the Rhode Island Dental Society and Reuben C. Bates, Secretary and Treasurer.

MONTHLY AVERAGES OF CERTIFIED MILK FOR YEAR 1937

	COCUMCUSSOC			CHERRY HILL (H. P. Hood)			FAIROAKS			Pasteur- ized	FERRYCLIFFE			HAMPSHIRE HILLS (Whiting's)			WALKER-GORDON		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.		B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	4.2	13.02	1,978	4.2	13.00	3,712	5.2	14.32	4,168	.....	.....	.....	.....	4	12.85	2	3.9	12.56	3,600
February	4.4	13.24	3,066	4.2	13.03	1,912	5.1	14.28	2,000	.....	.....	.....	.....	4	12.89	0	4	12.74	1,925
March	4.2	13.04	3,616	3.9	12.70	1,687	5.4	14.60	737	.....	.....	.....	.....	3.9	12.82	0	4	12.69	1,900
April	4.4	13.24	2,944	3.9	12.73	2,820	4.5	13.50	2,716	79	.....	.....	.....	4.1	12.94	0	3.9	12.61	2,740
May	4.4	13.18	3,687	3.9	12.74	1,975	4.5	13.03	1,868	8	.....	.....	.....	3.9	12.83	0	3.9	12.53	2,230
June	4.5	13.29	4,466	4	12.74	2,962	3.9	12.33	3,816	13	.....	.....	.....	3.9	12.66	0	4	12.63	3,075
July	4.5	13.03	3,905	3.9	12.66	3,210	4	12.71	8,955	653	4.6	13.63	15,628	3.9	12.48	0	4.1	12.68	2,740
August	4.3	13.04	2,222	3.9	12.57	3,650	4.4	13.13	2,555	38	4.7	13.75	12,511	3.9	12.36	16	4.1	12.75	4,250
September	4.4	13.20	3,150	4	12.68	2,450	3.9	12.79	3,355	37	5.6	14.64	805	3.9	12.59	11	4	12.66	3,600
October	4.5	13.55	1,506	4.1	12.97	2,875	4.1	13.12	4,875	225	5.8	14.32	1,506	3.9	12.54	25	3.9	12.57	3,800
November	4	12.76	4,555	4.1	12.85	3,337	4.4	13.37	1,483	287	5.8	14.77	2,005	3.9	12.46	7	4	12.57	3,450
December	4.3	13.18	2,178	4	12.69	7,500	4.4	13.47	1,350	922	5.6	14.73	4,485	4	12.64	5	4	12.77	2,825
Yearly Average	4.3	13.14	3,026	4	12.78	3,174	4.4	13.38	3,156	251*	5.3	14.30	6,156	3.9	12.67	6*	3.9	12.64	3,012

*Pasteurized

Rhode Island Hospital

SCHEDULE FOR APRIL, 1938

Thursday, April 7, 1938

Gyn Staff Meeting, 8:30 P. M.

Friday, April 8, 1938

G. U. Staff Meeting, 7:30 P. M.

Surg. Staff Meeting, 8:30 P. M.

Tuesday, April 12, 1938

Clinical Path. Conference, 12:00 noon

Tuesday, April 26, 1938

Clinical Path. Conference, 12:00 noon

Mondays

Surgical Grand Rounds, 10:00 A. M.

I Surg. Grand Rounds, April 11, 25

II Surg. Grand Rounds, April 4, 18

Thoracic Clinic, 4:30 P. M.

Tuesdays

Gastro-Intestinal Clinic, 9:30 A. M.

Surgical Grand Rounds, 10:00 A. M.

I Surg. Grand Rounds, April 12, 26

II Surg. Grand Rounds, April 5, 19

Wednesdays

Tumor Clinic, 10:00 A. M.

Thursdays

Orthopedic Grand Rounds, 9:00 A. M.

Thoracic Clinic, 11:30 A. M.

Gyn. Path. Conference, 11:30 A. M.

Fridays

Fracture Grand Rounds, 11:00 A. M.

Pediatric Grand Rounds, April 8, 22,

11:00 A. M.

Skin Clinic, 11:30 A. M. O. P. D.

Saturdays

Neurological Grand Rounds, 9:00 A. M.

Medical Conference, 10:00 A. M.

Woonsocket Hospital

The monthly Clinico-Pathological Conference was held February 28th, 1938. Final disposition of a case previously presented by Dr. G. G. Dupre was made. The autopsy failed to show any gross pathological condition. However, microscopical examination of sections of various organs proved the presence of miliary tubercles of the spleen, adrenals, kidneys and of mediastinal gland. Strangely enough, sections from the lungs and intestines did not reveal this condition.

The first case to be presented at this meeting was by Dr. Victor H. Monti. It was a case of Agranulocytic Angina of four weeks duration. Worthy of mention is the blood count. The white blood cell count dropped to 600 cells and for the past two weeks has remained near 1400 cells. This case will be further discussed at the next meeting.

The second case, presented by Dr. Thomas J. Lalor, was one of severe jaundice complicating a two months pregnancy.

LOCAL EVENTS*March 6*

The March series of Sunday Public Lectures under the auspices of the Rhode Island Medical Society was opened at the Medical Library by Dr. William Lessel Leet. He spoke on "Food, Weight and Health." Considering the questions why some people are sick and some well, why some are fat and others thin, he demonstrated the influence of diet in these conditions. The speaker was introduced by Dr. George L. Young.

March 10

At the meeting of St. Joseph's Hospital Staff Association, held at the Nurses' Auditorium at 8:45 P. M., Dr. Frederick H. O'Brien, Professor of Radiology at Tufts Medical School, spoke on "X-ray Treatment." Dr. William J. Butler opened the discussion.

March 11

The William W. Keen Medical Club, entertained by Dr. Eric Stone, considered the subject, "Prontylin."

March 13

Dr. Francis L. Burns gave a public lecture at the Medical Library. His subject was "The Com-

Dr. Frank J. Logler of Newport, graduate of Rhode Island State College and of Vanderbilt Medical School, began a two years internship at the Rhode Island Hospital on March 15. Dr. Logler spent a month as Interne at the Providence Lying-In Hospital.

Dr. Gilmore W. Soule, Interne at the Rhode Island Hospital for the past two years, has left for his home at Augusta, Maine. Dr. Soule is a graduate of Harvard Medical School.

On March 16, 1938, at the Providence Lying-In Hospital, to Dr. and Mrs. Lawrence T. Minish, a son, Lawrence Thaddeus Minish, 3rd. Dr. Minish is an Interne at the Rhode Island Hospital.

mon Cold and Its Complications." Among prophylactic measures, he emphasized the duty of those suffering from colds to avoid infecting others. For treatment, he stressed the importance of rest in bed and proper diet. Drugs should be used only on the advice of a physician. The lecture was illustrated with lantern slides. Dr. George L. Young presided.

March 15

The local group of members of the American College of Physicians held a special meeting at the Peters House of the Rhode Island Hospital at 5 P. M. Dr. Shields Warren of Boston spoke on "Recent Advances in Pathology of Diabetes." He showed a remarkable collection of lantern slides, many in color, illustrating the histology and pathology of the Islands of Langerhans. Dr. Charles F. Gornly presided and introduced the speaker.

March 15

The Amos Throop Medical Club was entertained by Dr. Herman C. Pitts. His subject was "Cancer of the Breast." Dr. Philip Batchelder presented the X-ray features and Dr. B. Earl Clarke demonstrated the pathological conditions.

March 18

The Providence Child Guidance Clinic and the Rhode Island Society for Mental Hygiene held an open meeting at the Medical Library at 4 P. M. Dr. Frederick H. Allen, Director of the Philadelphia Child Guidance Clinic, spoke on "Problems in Child Development."

March 18

Dr. Frederic V. Hussey entertained the Friday Night Medical Club. His subject was "Some Surgical Conditions of the Large Intestine." The paper was discussed by Dr. Arthur T. Jones, Dr. Guy W. Wells, Dr. Eliot A. Shaw, and by the members of the Club.

March 20

With the title "The Conquest of Pain, Plague and Pestilence," Dr. Albert H. Miller gave the third of the popular lectures at the Medical Library. In an account of modern medical progress he paid tribute to Dr. Charles V. Chapin for his work on sanitation in Providence. Dr. George L. Young presided and introduced the speaker.

March 21

Dr. Francis H. Chafee entertained the Thirty-four Medical Club. Professor Robert H. George was guest speaker.

OBITUARY

WILLIAM CHARLES McLAUGHLIN, M.D.

Dr. William Charles McLaughlin died at St. Joseph's Hospital on December 6, 1937, from a relapse of a duodenal ailment which had troubled him for nearly a decade. He was in his fifty-eighth year. He was born in Providence, January 19, 1880, the son of James H. and Mary McLaughlin. He received his early education in the Providence public schools, graduating from Classical High School at the age of seventeen. He matriculated at Brown University, became a member of Alpha Chapter of Phi Kappa fraternity, and graduated with the class of 1901. He then attended Harvard Medical School, from which he obtained an M.D. cum laude in 1905. After serving a general internship at the Carney Hospital and a full service at the Massachusetts Eye and Ear Infirmary, he terminated his medical training with a period of six months at the Massachusetts General Hospital, in the Nose and Throat Out-patient Department.

In September, 1908, Dr. McLaughlin opened an office on Broad Street, in Providence. From the start it was manifest that he was destined to be one of the leading specialists in his field of practice, a position he maintained to the time of his death. He served on the Eye and Ear Department of St. Joseph's Hospital for fifteen years and a like number as Consulting Surgeon. From the advent of his career up to 1933 he was a member of the Staff of the Eye, Ear, Nose and Throat Service of the Rhode Island Hospital. He was Aural Surgeon at the Charles V. Chapin Hospital from its establishment and Aural Surgeon-in-Chief from 1922. He was elected a member of the Commission of the Charles V. Chapin Hospital in 1934 and was its secretary at the time of his death. In the early days of his practice he was a member of the old School Committee and served two terms.

He was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, a Fellow of the American College of Surgeons, the New England Ophthalmological Society, and the New England Otological and Laryngological Society. He was a member of the Knights of Columbus and had attained the Fourth Degree, the Columbus Club, the Benevolent and Protective Order of Elks, the Friendly Sons of St. Patrick, the Irish Kings and the Round Table Sunshine Club.

In 1913, he married Catherine Rosemary Learson, of Roslindale, Massachusetts, a graduate nurse of the Long Island Hospital, the Boston Infants Hospital and the Massachusetts Charitable Eye and Ear Hospital. From this union there were seven children, five surviving:—Mary M., William C., Jr., Paul F., Arthur L., and Richard R.

Dr. McLaughlin was fearless in verbal combat and sought quarters of no antagonist, however exalted. No one ever questioned the sincerity of his friendship, the dependability of his word of honor. His native Irish wit stood him in good stead. Augmented by this gift his keenness in diagnosis and his operative skill placed him among the leading contemporary specialists in his field of action.

This society has lost a noble character, his wife a respected husband, his children an honored father, his father a distinguished son.

WILLIAM HINDLE, M.D.

FRANK MCCABE, M.D.

HARVEY E. WELLMAN, M.D.

Harvey Elijah Wellman was born in Providence on September 16, 1892, the son of D. Henry Wellman of South Attleboro and Emma I. (Wilson) Wellman of Providence. He obtained his preliminary education at Miss Baker's school on Almy Street and Moses Brown School, from which he graduated in 1910. Following this he attended Williams College, graduating in 1914 with the degree of B.A. He then did graduate work in chemistry at the Massachusetts Institute of Technology for two years, leaving there to accept a position with the Glenlyon Dye Works at Saylesville, Rhode Island. With the outbreak of the war, he resigned his position to join the United States Navy as a Pharmacist's Mate, serving with the Rhode Island Hospital unit, U. S. N. Base Hospital No. 4, first at Newport and later at Queenstown, Ireland. He was honorably discharged in January, 1919, and became Chemist in charge of the printing laboratory of the Dupont Company at Penn Grove, N. J. This position he held for two years, leaving to accept a similar appointment with the United States Finishing Company in Providence.

From the time of his service with the Base Hospital, his interest in medicine increased steadily, and in 1922 he decided to leave the field of chemistry and become a physician. He accordingly entered Harvard Medical school in that year and graduated

in 1926, following which he served a two years' internship at the Rhode Island Hospital. The next year he spent as Resident Physician at the same institution. The routine duties of this position he performed faithfully and well, but in addition, he was chiefly instrumental in effecting the much needed reorganization of certain departments; a task calling for tact and courage as well as persistent effort.

Dr. Wellman entered the private practice of medicine as an internist in 1930, and from that time on he made himself increasingly felt as an influence in the medical life of Providence. He was a member of the Staff at the Rhode Island, Charles V. Chapin, and Homeopathic Hospitals, and also served on the Staff of the Division of University Health of Brown University. He was a member of the Providence Medical Association, the Rhode Island Medical Society and the New England Heart Association; and was a Fellow of the American Medical Association and the American College of Physicians. He was one of the founders of the Thirty Four Medical Club of Providence. He was also a member of the University Club of Providence.

His death came suddenly as the result of an overwhelming gastro-intestinal infection on October 20, 1937.

Dr. Wellman never lost the seriousness of purpose which impelled him to become a physician at a relatively late period in his life, and the breadth of his educational experience was reflected in his personality. He cared for college boys and old people with equal felicity, and his patients were his friends. Stevenson's description of the Physician might well have been written for him. "Generosity he has, such as is possible to those who practise an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage. So that he brings air and cheer into the sick room, and often enough, though not so often as he wishes, brings healing."

WILFRED PICKLES, M.D.

PAUL C. COOK, M.D.

GEORGE EDWARD CLARK, M.D.

Dr. George Edward Clark, who was for a number of years a member of this Society, but who for reasons of failing health was unable to attend its meetings often, died on March 14, 1936, after a long illness.

He was born in Harsham, Sussex County, England, April 6, 1863. He received his preliminary education in private schools of this country and England and entered the University of Maryland in 1885, graduating with the degree of M.D. in 1889. After graduating, he took an internship at the Johns Hopkins Hospital, another year's internship at the New York Foundling Hospital, and then established himself in private practice of medicine in Skaneateles, New York. On April 9, 1892, he married Frances Anna Underhill, who survives him.

Throughout his many years of general practice it was always the psychological aspects of the patient's disease which intrigued him most. Working independently, he came to the conclusion that he had to treat the individual as a whole, a point of view which is being stressed more and more as time goes on. About 1928, he returned to hospital work, taking a position at the Rhode Island Hospital for Mental Diseases at Howard until ill health terminated his period of service there. After a course of treatment, he came to Butler Hospital in March, 1930. Here he continued his psychotherapeutic work and was instrumental in the cure of many seriously afflicted patients. The influence of his point of view was felt throughout the institution. He enjoyed nothing better than to sit down and explain his philosophy of psychiatry.

Dr. Clark was a member of the American Association for the Advancement of Science, the American Psychiatric Association, the Rhode Island Society for Neurology and Psychiatry, and the Providence Medical Association.

Unfortunately, there are not many in this audience who knew Dr. Clark personally, but all those who did have that opportunity, feel a deep sense of loss at his passing.

NILES WESTCOTT, M.D.

IRA C. NICHOLS, M.D.

RECENT BOOKS

TWENTY-FIVE YEARS OF HEALTH PROGRESS. A study of the mortality experience among the Industrial policyholders of the Metropolitan Life Insurance Company, 1911 to 1935. By Louis I. Dublin, Ph.D., and Alfred J. Lotka, D.Sc. Cloth, pp. 611. Metropolitan Life Insurance Company, New York, 1937.

This compendium of statistics covers a survey from a health standpoint, of the years 1911 to 1935. After a general discussion of the mortality from all causes, the individual

diseases are taken up. Tables giving the death rates are given in great detail and of unquestioned accuracy. In most instances the population is subdivided by sex and by color. Accompanying these tables is a full but concise discussion, summarizing the information given by the table. In this way the reader is given a perspective of the situation by the text and a detailed study by the tables themselves. In the appendix are given tables of mortality experience and the method of compilation and analysis of data. An excellent index is also included.

The information contained in this well-written volume is, in a way, unique. A mass of data regarding the mortality experience of so large a group of persons over so long a period of time is unobtainable from any other source. It pays a fitting tribute too to the physicians of this country; for the facts definitely show the marked strides made by the profession in combatting diseases, particularly those of childhood, tuberculosis, syphilis, pernicious anemia, not to mention the results seen by the advance of surgery.

It would repay the general practitioner to thumb over this volume in the library, while waiting for a meeting to begin. The specialist will benefit by reading the section in which he is particularly concerned, while industrial and insurance physicians should read it from cover to cover and find it absorbing.

FRANCIS H. CHAFEE, M.D.

THE TRAFFIC IN HEALTH. By Charles Solomon, M.D. Assistant Clinical Professor of Medicine, Long Island College of Medicine. Cloth, pp. 393, \$2.75, Navarre Publishing Company, Inc., New York, 1937.

Dr. Solomon in this book discusses with a good deal of detail most of the types of frauds, fads, and fancies that are ever present and luring the less well-informed to spend their money and neglect their health. In his introduction he states that there are no secrets in Medicine, that proprietary "remedies" can be classified under five general heads as follows. 1. Mixture of obsolete or incompatible drugs. 2. Drugs that may be beneficial in palliating certain symptoms, but perhaps only under specific circumstances that the physician alone is able to judge. 3. Completely irrational mixtures. 4. Harmful drugs or mixtures of same. 5. Pure economic fraud. He is careful to state that in contrast to a proprietary "medicine," which may be quite exemplary, a proprietary "remedy" or nostrum is a secret preparation not sold for what it is but on a basis of what it is supposed to do.

Most of the remainder of the book deals with specific examples of these proprietary "remedies," everything from cosmetics to cancer "cures." The uselessness and the dangers of these drugs and the inadequacies of legislation against them are pointed out. There is also an attempt made to reveal to the individual a sane attitude toward disease in relation to himself. This is done by depicting and explaining many of the common symptoms of disease and telling what should be done for them. A good deal of interesting and valuable information is presented but the style is wordy and rather documentary.

JOHN C. HAM, M.D.